June 9, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: **MDR Tracking #: M2-03-1011-01**

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board certified in orthopedic surgery. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History
This case concerns a female who sustained a work related injury on ___. The patient underwent an MRI that showed osteochondral defect of the posterolateral aspect of the talar dome. The patient underwent an arthroscopic debridement with OCD of the right ankle on 9/30/02. The patient was treated with post surgical therapy and anti-inflammatory medications. A post surgical MRI showed focal deformity in the medial talar dome without lose bodies.

Requested Services
Arthroplasty, major bone graft.

Decision
The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision
The ___ physician reviewer noted that this case concerns a female who sustained a work related injury to her right ankle on ___. The ___ physician reviewer also noted that the patient underwent an arthroscopic debridement with OCD of the right ankle on 9/30/02. The ___ physician reviewer indicated that this patient has had adequate time to recover from the previous procedure. However the ___ physician reviewer noted that this patient remained symptomatic. The ___ physician reviewer explained that a repeat MRI showed that the lesion is persistent. The ___ physician reviewer indicated that the options for this patient are few. The ___ physician reviewer explained that the requested procedure would be the treatment most likely to help this patient. The ___ physician reviewer also explained that there is both European and American literature documenting success with the recommended procedure. (Hangody L,

Fules, Peter. Autologous osteochondral mosaicplasty for the treatment of full-thickness defects of weight bearing joints: ten years of experimental and clinical experience. J Bone Joint Surg Am 2003; 85-A Suppl 2:25-32. Gautier E, Kilker, D, Jakob, RP. Treatment of artilage defects of the talus by autologous osteochondral grafts. J Bone Joint Surg Br 2002 Mar;84(2):237-44. Assenmacher JA, Kelikian, AS Gottlob C, Kodros, S. Arthroscopically assisted autologous osteochondral transplantation for osteochondral lesions of the talar dome: an MRI and clinical follow-up study. Foot Ankle Int 2001 Jul;22(7):544-51.) The ___ physician reviewer further explained that the requested treatment is within current standards of care. Therefore, the ___ physician consultant concluded that the requested arthroplasty with/or and major bone graft is medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 9th day of June 2003.